MDR Tracking Number: M5-04-1776-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-17-04. .

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visit, special report, and functional capacity evaluation for date of service 9/30/03 was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 9/30/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 7th day of June 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

May 14, 2004

MDR Tracking #: M5-04-1776-01
IRO Certificate#: IRO 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic Medicine. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case

Clinical History
This 51 year old female sustained injuries at work on ___ while lifting large boxes of filters. The patient had complaints of pain in the back of her right hip (sacroiliac area) with radiation down her front leg. The initial impression was chronic sprain/strain of the lumber spine. Documentation states that her overall pain is “2” on a scale from 1- to 10. The treatment plan included joint mobilization, physical medicine modalities, therapeutic massage, and therapeutic phonophoresis.

Requested Services (s)
Special reports, office visit for established patient, and functional capacity evaluation (FCE).

Decision
It is determined that the special reports, office visit for established patient, and FCE were medically necessary to treat this patient’s condition.

Rationale/Basis for Decision
The patient was examined by the chiropractor on 05/30/02 and her original date of injury was ___. The patient’s neurological examination was unremarkable and lumbar ranges

of motion were reduced. The patient underwent a FCE on 08/21/02a dn the report indicated she was functioning at the light physical demand level. The patient underwent a re-examination on 09/24/02 and her lumbar ranges of motion were nearly normal. She underwent a second FCE on 10/11/02 and the report indicated she was still functional at the light physical demand level.

A subsequent re-examination on 09/03/03 revealed that the patient's lumbar ranges of motion were normal and she underwent a FCE on 10/01/03 that revealed she was functioning at the medium physical demand level. Additional documentation from the doctor indicated that FCE and examination were done in order to determine if the patient could be released to work without restrictions. As a result of the FCE, the patient's work restrictions were lifted.

Information Submitted to ___ for TWCC Review

Information Submitted by Requestor:

- Final Request for Medical Dispute Resolution dated 03/26/04
- Medicine Ground Rule I (E)(2)(a)
- Functional Capacity Evaluation dated 08/21/02, 10/01/03, and 10/11/02
- Initial Evaluation from ___ dated 05/30/02
- Interim Report from ___ dated 09/30/03